

CHAPTER 7

Regulations, Licensure and Policy: The functional abilities essential for competent nursing practice

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In nursing, as in any profession or occupation, the practitioner (job holder) must possess a unique set of knowledge, skills and abilities³ (KSAs) that permit the individual to competently carry out his or her job responsibilities. Two groups of KSAs are essential to the practice of nursing: those that are domain specific (i.e., specific to nursing) and those that are non-domain specific. The non-domain specific abilities underlie the performance of domain specific tasks and activities. For example, without the ability to grasp a catheter (with or without an accommodation), it is impossible to insert it into a body cavity. (Whether the ability to insert a catheter into a body cavity is essential for licensure and employment as a nurse, while germane to the focus of this conference, is beyond the scope of this paper.)

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³ “Ability” is defined as the relatively enduring attributes of the individual performing the tasks of an occupation. (Fleishman & Mumford, 1988; McCormick, 1979).

Another example of the relationship between a non-domain specific and a domain specific ability is as follows: The ability to store information in short- and long-term memory is essential for information processing and decision-making. An application of this ability is exemplified by the collection, storage, analysis and interpretation of a patient's signs and symptoms for the purpose of problem identification and its nursing management. These behavioral components of practice are an integral component of competence (National Council, 1996) and therefore have relevance to the regulation of nursing practice, the education of future and current nurses, and their subsequent licensure and employment.

Passage of the Americans with Disabilities Act (ADA) provided individuals with physical or mental disabilities protection from discrimination in areas such as employment, public accommodations, communication and access to services. To be covered under the act, individuals must demonstrate that they possess either: (1) a physical or mental impairment that substantially limits one or more major life activities (e.g., walking, seeing, hearing, learning, etc.); (2) a record of such impairment; or (3) that they are regarded as having such an impairment.¹ Title I of the ADA prevents discrimination against employees with disabilities and requires that an employer provide a disabled employee with a "reasonable accommodation."

Within nursing education, service and regulation, passage of the ADA raised a number of issues, including the need to specify the non-domain specific functional abilities that a nurse must possess in order to provide safe and effective nursing care. Explication of these abilities would be useful in evaluating existing regulatory, workplace, and educational policies and inform any needed revisions as a consequence of passage of the ADA. To address this need, the National Council of State Boards of Nursing undertook a series of studies (Chornick, 1993a, 1993b; Yocom, 1993) that culminated in a study designed to validate the non-domain specific functional abilities essential for nursing practice (Yocom, 1996). The methodology and selected results of the study that pertain to the practice of registered nurses will be summarized in this paper².

¹ 28 C.F.R. §36.104

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A job analysis methodology was used to identify and compare the abilities required by nurses employed in a variety of positions and work settings. The target population was all licensed practical/vocational nurses (LPN/VNs) and registered nurses (RNs), including advanced practice nurses (APNs), practicing in the United States. Based on response-rate knowledge gained in previous job analysis and role delineation studies, a random sample of 10,000 nurses was taken from all nurses currently licensed in 28 states.³ Collectively, the sample represented all nurses licensed to practice in urban and rural areas of large and small states in all geographic regions of the United States.

A self-administered questionnaire, developed based on focus group input (Chornick, 1993a), pilot work (Chornick 1993b), a literature review, and consultation with experts, contained 97 representative attributes (see Table 1) grouped within 16 functional ability categories: Gross motor skills, fine motor skills, physical endurance, physical strength, mobility, hearing, visual, tactile, smell, reading, arithmetic (counting, measuring, computing), emotional stability, analytical thinking, critical thinking, interpersonal skills, and communication skills (written, oral). Content validity and internal consistency of the total scale and all subscales were supported. Final assignment of attributes to subscales was based on the results of a factor analysis.

Each participant was requested to indicate if it was essential for him/her to be able to possess a specific attribute in order to provide minimally safe and effective care to his/her clients. Additional items requested demographic and work environment (setting, position title, shift/hours worked, involvement in direct client care) information.

A multiphase mailing process was used to collect data. The initial mailing included an explanation of the study, a questionnaire and a stamped, return envelope. With postcard follow-up to non-respondents and adjustment for non-deliverables, a 36.6% response rate (n=3,660) was attained. Of these, 2,677 (73%) were RNs and APNs who were currently employed in nursing at least 20 hours per week. A follow-up telephone survey to randomly selected non-respondents revealed no significant differences between this group's characteristics and responses and those of the respondents. The

³States providing data tapes to the National Council for use in another project, granted permission for their use in this study.

demographic and work environment characteristics of respondents was also compared with those of participants in a role delineation study performed during the preceding year and for which there was a higher response rate (Yocom & Chornick, 1995). No statistically significant differences were identified.

The RN participants practiced in one or more of 19 different types of acute care, long-term care, community and home care settings. The most frequently reported position titles were those of: staff nurse (51%), charge nurse (27%), home health or community health nurse (14%) and supervisor (12%). Although the full variety of work shifts and shift lengths (8, 10, 12 hours) were reported, the majority worked eight hours per day on the day shift. Eighty percent reported they provided or assisted with the provision of direct care; 14% provided indirect care and the remainder were either not engaged in clinical practice or did not respond to the item.

The percent of participants indicating that possession of an attribute was essential to their delivery of care on the previous workday was calculated for each item. Participants were also grouped based on three factors: the specific work setting (e.g., acute care, anesthesia, occupational health, psychiatry), type of position (e.g., administrator, staff nurse), and level of involvement in the delivery of patient care (e.g., direct, indirect). To be included in an analysis, each sub-group had to contain data from a minimum of 30 respondents. The percentages of subgroup members indicating that an attribute was essential was calculated for each attribute and then examined for each subgroup within a factor and for various combinations of factors (e.g., staff nurses involved in direct patient care by type of work setting). For the purposes of this study, an attribute was determined to be essential for the delivery of safe, effective patient care if 95% of those in the analysis group responded affirmatively to the stimulus question.

As a result of these analyses, a core set of non-domain specific, functional abilities essential for RN practice was identified. For RNs working in any employment setting, in any position and involved in the provision of either direct or indirect patient care (i.e., the entire group taken as a whole, n=2,537), 17 attributes were identified⁴. These were as follows:

⁴ Source: Yocom, (1996); Table 23.

<i>Attribute</i>	<i>Functional Ability Category</i>
Write with pen or pencil	Fine motor skills
Hear normal speaking level sounds	Hearing
Read and understand columns of numbers	Arithmetic competence
Tell Time	
Monitor own emotions	Emotional stability
Transfer knowledge from one situation to another	Analytical thinking
Process information	
Evaluate outcomes	
Problem solve	
Prioritize tasks	
Use long-term memory	
Use short-term memory	
Sequence information	Critical thinking
Establish rapport with clients	Interpersonal skills
Establish rapport with co-workers	
Interact with others	Communication skills
Convey information through writing	

Placing all the RNs in one group prior to identifying the core attributes eliminated the inclusion of attributes that are essential in settings where very few individuals worked (e.g., industrial settings and out-patient clinics). Therefore, another step was introduced: All items where 95% of the individuals employed in any position and involved in the provision of either direct or indirect patient care within a specific clinical setting were identified and then the data were compiled. This resulted in the inclusion of four additional attributes to the "core" group of attributes identified above⁵. These were: *Perform multiple responsibilities, synthesize knowledge and skills, respect differences in clients, explain procedures*. Therefore, these 21 core attributes are essential for safe and effective practice as an RN. With the exception of "writing with a pen or pencil," "hear normal speaking level sounds" and "convey information through writing," these attributes represent higher level cognitive functioning and psychosocial abilities.

Additional attributes associated with psychomotor functioning and the senses are essential when work setting and level of involvement in the delivery of patient care are considered. Based on a

⁵ Source: Yocom (1996); Table 22.

high degree of uniformity in responses, the multiple settings in which RNs were employed were collapsed into twelve settings, each with a minimum group size of 30. These 12 settings represented critical care (ICU, ED, PAR), acute care (medical-surgical, pediatrics, labor and delivery, nursery), anesthesia, surgery (in- and out-patient), psychiatry, long-term care (intermediate and skilled care), residential care, home health, occupational health, outpatient clinics, physician offices, and school settings. A total of 78 essential attributes, representing all 16 functional ability categories, were identified. Of these, 29 were identified as essential for practice in all 12 work settings. These are identified by an (*) in Table 2. As with the previously identified 21 “core” attributes, the majority represent higher level cognitive functioning and psychosocial abilities. The essential attributes for RNs providing direct care in five types of clinical settings (acute care, anesthesia, critical care, surgery and long-term care) are reported in Table 2. As can be seen, there is a great degree of similarity among these four settings.

In the remaining settings, the diversity was much greater. For example, RNs providing direct patient care in psychiatric settings, indicated that, in addition to the 21 core attributes, the following were also essential⁶:

Attribute	Functional Ability
Maintain physical tolerance	Physical endurance
Defend self against combative client	Physical strength
Walk	Mobility
Move quickly	
Hear auditory alarms	Hearing
See objects up to 20 feet away	Visual
Detect smoke	Smell
Speak on telephone	Communication skills
Teach	
Identify cause-and-effect relationships	Critical thinking
Negotiate interpersonal conflicts	Interpersonal skills
Establish therapeutic relationships	Emotional stability
Handle strong emotions	

⁶ Source: Yocom (1996); Table 19

This study demonstrated that the level of involvement in delivery of patient care, work setting, and position impacted the types of functional abilities that an RN must possess in order to provide safe, effective patient care. Despite this diversity, a core set of 21 attributes, representing eight functional ability categories was identified. Of these, the majority represented higher cognitive functioning and psychosocial skills. In addition, there are a large number of attributes that are common to a majority of the various work settings and, although not reviewed in this paper, job positions.

The knowledge gained from this study can be used to inform policy evaluation and decision-making by boards of nursing and by employers and educators. The position-specific and employment setting-specific information can be a valuable resource during career counseling opportunities— both with practicing nurses who acquired a disability following initial licensure and with individuals considering nursing as a career.

Within each state, the board of nursing has a legislative mandate to protect the public from incompetent providers of nursing care. When evaluating the competence of licensure applicants and licensees, the board cannot ignore or dismiss this mandate. *However, the presence of a disability that impacts an individual's ability to demonstrate competence in these areas should not be considered in isolation from the use of accommodations to compensate for a noted "deficiency."*

In the event a nurse (or prospective nurse) has a disability that negatively impacts performance of the essential "core" abilities/attributes or those that are specific to a position/role or work setting, answers to the following series of questions are critical:

1. Can the individual, with or without reasonable accommodation, engage in the activities that are essential for the delivery of safe, effective nursing care?
2. In what clinical setting(s) or positions is the individual best suited for employment?
3. Does the individual have insight into the implications of his/her disability?
4. In the event of "accommodation failure," does the individual have insight into the potential consequences as they relate to patient safety?

Table 1. Functional ability categories and Representative attributes.¹⁰

<p><u>Gross Motor Skills</u> Move within confined spaces Sit and maintain balance Stand and maintain balance Reach above shoulders (e.g., IV poles) Reach below waist (e.g., plug electrical appliance into wall outlets)</p> <p><u>Fine Motor Skills</u> Pick up objects with hands Grasp small objects with hands (e.g., IV tubing, pencil) Write with pen or pencil Key/type (e.g., use a computer) Pinch/pick or otherwise work with fingers (e.g., manipulate a syringe) Twist (e.g., turn objects/knobs using hands) Squeeze with finger (e.g., eye dropper)</p> <p><u>Physical Endurance</u> Stand (e.g., at client side during surgical or therapeutic procedure) Sustain repetitive movements (e.g., CPR) Maintain physical tolerance (e.g., work entire shift)</p> <p><u>Physical Strength</u> Push and pull 25 pounds (e.g., position clients) Support 25 pounds of weight (e.g., ambulate client) Lift 25 pounds (e.g., pick up a child, transfer client) Move light objects weighing up to 10 pounds (e.g., IV poles) Move heavy objects weighing from 11 to 50 pounds Defend self against combative client Carry equipment/supplies Use upper body strength (e.g., perform CPR, physically restrain a client) Squeeze with hands (e.g., operate fire extinguisher)</p> <p><u>Mobility</u> Twist Bend Stoop/squat Move quickly (e.g., response to an emergency) Climb (e.g., ladders/stools/stairs) Walk</p> <p><u>Hearing</u> Hear normal speaking level sounds (e.g., person-to-person report) Hear faint voices Hear faint body sounds (e.g., blood pressure sounds, assess placement of tubes) Hear in situations when not able to see lips (e.g., when masks are used) Hear auditory alarms (e.g., monitors, fire alarms, call bells)</p> <p><u>Visual</u> See objects up to 20 inches away (e.g., information on a computer screen, skin conditions) See objects up to 20 feet away (e.g., client in a room) See objects more than 20 feet away (e.g., client at end of hall) Use depth perception Use peripheral vision Distinguish color (e.g., color codes on supplies, charts, bed) Distinguish color intensity (e.g., flushed skin, skin paleness)</p> <p><u>Tactile</u> Feel vibrations (e.g., palpate pulses) Detect temperature (e.g., skin, solutions) Feel differences in surface characteristics (e.g., skin turgor, rashes) Feel differences in sizes, shapes (e.g., palpate vein, identify body landmarks) Detect environmental temperature (e.g., check for drafts)</p>	<p><u>Smell</u> Detect odors from client (e.g., foul smelling drainage, alcohol breath, etc.) Detect smoke Detect gases or noxious smells</p> <p><u>Reading</u> Read and understand written documents (e.g., policies, protocols)</p> <p><u>Arithmetic Competence</u> Read and understand columns of writing (flow sheet, charts) Read digital displays Read graphic printouts (e.g., EKG) Calibrate equipment Convert numbers to and/or from the Metric System Read graphs (e.g., vital sign sheets) Tell time Measure time (e.g., count duration of contractions, etc.) Count rates (e.g., drips/minute, pulse) Use measuring tools (e.g., thermometer) Read measurement marks (e.g., measurement tapes, scales, etc.) Add, subtract, multiply, and/or divide whole numbers Compute fractions (e.g., medication dosages) Use a calculator Write numbers in records</p> <p><u>Emotional Stability</u> Establish therapeutic boundaries Provide client with emotional support Adapt to changing environment/stress Deal with the unexpected (e.g., client going bad, crisis) Focus attention on task Monitor own emotions Perform multiple responsibilities concurrently Handle strong emotions (e.g., grief)</p> <p><u>Analytical Thinking</u> Transfer knowledge from one situation to another Process information Evaluate outcomes Problem solve Prioritize tasks Use long-term memory Use short-term memory</p> <p><u>Critical Thinking</u> Identify cause-effect relationships Plan/control activities for others Synthesize knowledge and skills Sequence information</p> <p><u>Interpersonal Skills</u> Negotiate interpersonal conflict Respect differences in clients Establish rapport with clients Establish rapport with co-workers</p> <p><u>Communication Skills</u> Teach (e.g., client/family about health care) Explain procedures Give oral reports (e.g., report on client's condition to others) Interact with others (e.g., health care workers) Speak on the telephone Influence people Direct activities of others Convey information through writing (e.g., progress notes)</p>
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¹⁰ Source: Yocom, C.J. (1996). *Validation study: Functional abilities essential for nursing practice*. Chicago: National Council of State Boards of Nursing. (Available in: National Council of State Boards of Nursing (1999). *Guidelines for using results of functional abilities studies and other resources (Appendix A; pp. 56-57)*. Chicago: author.) Reproduced with permission.

Table 2. Functional Abilities/Attributes essential for the delivery of safe, effective nursing care by RNs providing direct care and employed in the following areas: acute care (AC) , anesthesia (AN), critical care (CC), surgical suite (SU), and long term care (LT).⁸

⁸ Source: Yocom, C.J. (1996). *Validation study: Functional abilities essential for nursing practice*. Chicago: National Council of State Boards of Nursing. (Available in: National Council of State Boards of Nursing (1999). *Guidelines for using results of functional abilities studies and other resources (Tables 18 and 19; pp. 45-47)*. Chicago: author.) Reproduced with permission.

<p>Gross Motor Skills Stand and maintain balance (AN, LT)⁹ Reach above shoulders (e.g., IV poles) (LT) Reach below waist (e.g., plug electrical appliance into wall outlets) (LT) Move within a confined space (AC, AN, CC, LT)</p> <p>Fine Motor Skills *Pick up objects with hands **Grasp small objects with hands (e.g., IV tubing, pencil) Write with pen or pencil Pinch/pick or otherwise work with fingers (e.g., manipulate a syringe) Twist (e.g., turn objects/knobs using hands) Squeeze with finger (e.g., eye dropper) (AC)</p> <p>Physical Endurance Stand (e.g., at client side during surgical or therapeutic procedure) (AN, LT) Sustain repetitive movements (e.g., CPR) (AC, AN, SU, LT) Maintain physical tolerance (e.g., work entire shift)</p> <p>Physical Strength Push or pull 25 pounds (e.g., position clients) (AC, AN, LT) Lift 25 pounds (e.g., pick up a child, transfer client) (AC, AN, LT) Move light objects weighing up to 10 pounds (e.g., IV poles) Carry equipment/supplies (AN) Use upper body strength (e.g., perform CPR, physically restrain a client) (AC, AN) Squeeze with hands (e.g., operate fire extinguisher)</p> <p>Mobility Twist Bend (AN) Stoop/squat (AN) Move quickly (e.g., response to an emergency) Walk</p> <p>Hearing *Hear normal speaking level sounds (e.g., person-to-person report) Hear faint body sounds (e.g., blood pressure sounds, assess placement of tubes) (AC, CC, SU, LT) Hear in situations when not able to see lips (e.g., when masks are used) (AC, CC, LT) Hear auditory alarms (e.g., monitors, fire alarms, call bells)</p> <p>Visual *See objects up to 20 inches away (e.g., information on a computer screen, skin conditions) See objects up to 20 feet away (e.g., client in a room) (AN, SU) See objects more than 20 feet away (e.g., client at end of hall) Use depth perception (AC, LT) Use peripheral vision (AC, CC) Distinguish color intensity (e.g., flushed skin, skin paleness)</p> <p>Tactile Feel vibrations (e.g., palpate pulses) Detect temperature (e.g., skin, solutions) Feel differences in surface characteristics (e.g., skin turgor, rashes) (SU) Feel differences in sizes, shapes (e.g., palpate vein, identify body landmarks)</p> <p>Smell Detect smoke (CC, SU) Detect gases or noxious smells (CC, LT)</p>	<p>Reading *Read and understand written documents (e.g., policies, protocols)</p> <p>Arithmetic Competence *Read and understand columns of writing (flow sheet, charts) Read digital displays (LT) Read graphic printouts (e.g., EKG) Read graphs (e.g., vital sign sheets) (LT) *Tell time Measure time (e.g., count duration of contractions, etc.) (AC, SU, LT) Count rates (e.g., drips/minute, pulse) Use measuring tools (e.g., thermometer) Read measurement marks (e.g., measurement tapes, scales, etc.) Add, subtract, multiply, and/or divide whole numbers Compute fractions (e.g., medication dosages) (SU) *Write numbers in records Calibrate equipment (AC, CC, SU, LT) Convert numbers to and from metric system (AC, CC, SU, LT)</p> <p>Emotional Stability Establish therapeutic boundaries *Provide client with emotional support *Adapt to changing environment/stress *Deal with the unexpected (e.g., client going bad, crisis) *Focus attention on task *Monitor own emotions *Perform multiple responsibilities concurrently Handle strong emotions (e.g., grief) (AN)</p> <p>Analytical Thinking *Transfer knowledge from one situation to another *Process information *Evaluate outcomes *Problem solve *Prioritize tasks *Use long term memory *Use short term memory</p> <p>Critical Thinking Identify cause-effect relationships *Synthesize knowledge and skills *Sequence information</p> <p>Interpersonal Skills Negotiate interpersonal conflict (AN, LT) Respect differences in clients *Establish rapport with clients *Establish rapport with co-workers</p> <p>Communication Skills Teach (e.g., client/family about health care) (AN) *Explain procedures *Give oral reports (e.g., report on client's condition to others) *Interact with others (e.g., health care workers) Direct activities of others (AC, AN, SU) *Convey information through writing (e.g., progress notes) Speak on the telephone (AN)</p>
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NOTE: * Identified as essential by 95% of RNs in each of the 12 work settings who were providing direct patient care..

References

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⁹ Indicates clinical setting where possession of the attribute was *NOT identified* as essential to safe, effective practice (AC=acute care, AN = anesthesia, CC = critical care, SU = surgical suite, LT = long term care (skilled, intermediate)).

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Addition to Position Paper Presentation

The purpose of the presentation is to discuss a study published by the National Council of State Boards of Nursing (NCSBN) in 1996. The study identifies essential functions and abilities as they relate to the practice of nursing. Dr. Yocom presented the intent of the study and how the data from the study should be used in contrast to how the study has been misused.

The focus of the paper is related to passage of the ADA and the issues this raised with regard to nursing practice, education and regulation. The NCSBN study focused on identifying the non-domain specific functional abilities that a nurse must possess in order to practice and provide safe, effective nursing care in specific types of positions, roles or job settings.

Explication of these abilities would be useful in evaluating existing regulatory, workplace and educational policies and could be used as the basis for any needed revisions as a consequence of the ADA implementation. The study has been thoroughly described in Dr. Yocom's preceding manuscript. A key point here is to understand that this study represents the final step in a three-step process used to identify the non-domain specific skills needed to be able to practice nursing. Specifically the steps were:

- A focus group consisting of individuals with disabilities and without disabilities was convened.
- An employer survey was conducted.
- Job analysis completed by employed nurses.
- Purpose was to validate the essential non-domain-specific functional abilities or attributes that a nurse must possess in order to perform nursing activities safely and effectively in a variety of work settings and positions.
- The target population was all registered nurses (RNs) and licensed practical vocational nurses (LPN).
- A random sample of 10,000 nurses was selected to participate.
- A self-administered questionnaire was used to collect data. Each respondent was asked to indicate if possession of the ability or attribute was essential for him or her to possess in

order to provide safe and effective care to patients within the respondent's current role, position and job setting.

The study identified 97 attributes assigned to 16 categories of functional abilities. The lists are appended to the manuscript. Dr. Yocom emphasized that "This is not 'THE' list that you have to possess; rather it is a representative list of the skills and abilities that you may have to possess. Think of this list as the items on the questionnaire. This is where people have been misusing the study by stating that if you want to be a nurse, you've got to be able to do all of these things included on the list. That is not true! This was only part of the questionnaire."

Dr. Yocom addressed the methodology and results. She discussed content validity and internal consistency of the total scale and subscales. She described the respondents and noted that the final sample represented a 36 percent response rate, which "was a little bit lower than we had expected." She also noted that "We believe one of the reasons for this [low response rate] was the purpose of the study, and that individuals who did have a disability, even though we promised confidentiality of responses, may have been hesitant to respond for fear of some type of retribution or the initiation of an investigation by the board. This may be a valid concern based on some of the information that we heard in the focus groups."

Dr. Yocom addressed the methods used to evaluate respondents' data and assure its validity through the use of a telephone survey to a randomly selected group of non-respondents. Since there were no differences between the two groups, it was concluded that the respondent data was representative.

Dr. Yocom continued with a thorough discussion of the data analysis phase of the study. She addressed the identification of what are the essential nondomain-specific abilities that a nurse needs to possess.

She stated: "Well, first we had to define essential. When you look at the dictionary definition of essential, it means something has to be present. However, in research we consider something called measurement error. Therefore, we set our definition as follows: for an attribute to be identified as essential, 95 percent of the respondents in

an analysis group had to indicate that, to provide safe and effective care, it was essential for them to possess the attribute or the characteristic that they were responding to."

Dr. Yocom continued: "Now, when we looked at the data analysis results for all RNs and APNs, regardless of position, work setting, and involvement in direct or indirect care (n = 2,677) a group of 21 attributes were identified as essential for practice. In other words, they said these are the attributes that nurses need to possess, this is the core list that you need to be able to do to function as a nurse."

Dr. Yocom presented the tables of core essential abilities: "Write with pen or pencil; hear normal speaking level sounds; read and understand columns of writing, in other words, columns of numbers, think of flow sheets; tell time; perform multiple responsibilities concurrently; monitor your own emotions — in other words, keep them under control; transfer knowledge across situations; process information; evaluate outcomes; problem solve; prioritize tasks; use long-term memory; use short-term memory; sequence information; synthesize knowledge and skills; establish rapport with clients and with co-workers; respect differences in clients; be able to interact with others; convey information through writing — think broadly — and explain procedures. These are the 21 core attributes or abilities; they represent 8 of the 16 different categories of functional abilities.

"I think you're hearing now a lot of the things some of the speakers were saying this morning and this afternoon. If you think about it, the majority of these represent higher-level cognitive skills and communication and interpersonal skills. You didn't see things on this list like 'pick up a tube.'"

Dr. Yocom continued with a discussion of practice setting. "Based on the high degree of uniformity in responses across the multiple settings in which RNs were employed, the numerous settings were collapsed into 12 groups. Within these 12 settings, a total of 78 essential attributes, distributed across all 16 categories, were identified when we looked at each of these 12 settings. Of these 78 attributes, 29 were essential for practice in all 12 areas." (These are identified in Table 2).

"The essential attributes for RNs providing direct care in five of the areas—acute care, anesthesia, critical care, surgery, and long-term care—are reported in Table 2. As can be seen, there is a great deal of similarity among the four settings." As an example, let's take the very first one that's on the list under gross motor skills. It says stand and maintain balance. First of all, it does not have an asterisk in front of it, so its not one of the 29 attributes that applies to all 12 settings.

"In the remaining settings, the diversity was much greater, such as in psychiatry, occupational health, the outpatient clinics, physicians offices and school health. For example, in psychiatry, nurses involved in direct care as a staff nurse, there is a different set of additional attributes, not the 78 included in Table 2. In addition to the 21 core essential attributes, the additional attributes are: Defend yourself against a combative client; walk; move quickly; pinch, pick or otherwise work with your fingers; maintain physical tolerance; speak on the phone; teach; identify cause-and-effect relationships; negotiate interpersonal conflicts; establish therapeutic relationships; handle strong emotions; hear auditory alarms; see objects up to 20 feet away; detect smoke. This should gives you a feel for the differences in the attributes essential for practice in psychiatry as opposed to the more traditional acute care and medical-surgical units."

Dr Yocom referred back to her paper to describe the following issues.

This study identified the attributes essential for involvement in delivery of care. Delivery of patient care, work setting and position impacted the types of functional abilities that an RN must possess in order to provide safe, effective patient care.

"Despite this diversity, a core set of 21 attributes representing 8 functional ability categories were identified. That's across all nurses, all settings, et cetera. Of these 21, the majority represented higher cognitive functioning and psychosocial skills. In addition there are a large number of attributes that are common to a majority of the various work settings and, although not reviewed in this paper, today, to various job positions. There are also a large number of psychomotor attributes that are essential for care delivery in the acute care, critical care, anesthesia, long-term care and surgical settings."

The knowledge gained from this study can be used to inform policy evaluation and decision-making by boards of nursing and by employers and educators. The position-specific and employment setting-specific information can be a valuable resource during career counseling opportunities both with practicing nurses who acquired a disability following their initial licensure and with individuals considering nursing as a career.

Within each state, the board of nursing — as we heard about earlier — has a legislative mandate to protect the public from incompetent providers of nursing care. When I say incompetent, this is an equal opportunity group. So when evaluating the competency of licensees, the board cannot ignore or dismiss this mandate. However, the presence of a disability that impacts an individual's ability to demonstrate competence in these areas should not be considered in isolation from the accommodations that can be used to compensate for a noted deficiency and, I would add, the setting where they intend to practice.

In the event a nurse or prospective nurse does have a disability that impacts performance of an essential core ability or attribute or of those that are specific to a position, role, or work setting, answers to the following set of questions is critical:

1. Can the individual, with or without reasonable accommodation, engage in the activities that are essential for the delivery of safe and effective nursing care?
2. In what clinical setting is the individual best suited for employment?
3. Does the individual have insight into the implications of his or her disability with regards to patient safety?
4. In the event of accommodation failure, does the individual with the disability have insight into potential consequences as they relate to patient safety?

Dr. Yocom continued: "Now, a comment on these four questions. Again, I think they're equal opportunity. For example, I haven't seen an OB unit since I graduated from nursing school in 1964. I am unsafe in any OB unit. I haven't been in clinical practice since 1985. So I'm

probably unsafe across all clinical areas. When I applied for a position at Rutgers, after I left the National Council, I made it very clear to my potential employers that I had not worked in clinical practice for over 15 years. Therefore, I see these questions also applying to me."

"On that note, I hope that you all have a better understanding of the purposes of this study and how the results of it should be used. And my suggestion would be to focus on those core attributes that represent the higher cognitive skills, the psychosocial interaction and communication skills. Thank you."

Regulations, Licensure and Policy: The functional abilities essential for competent nursing practice

Response

Vickie Sheets, JD, RN, CAE¹³

This audience is quite stalwart to be hanging in here this late this afternoon. I'm very pleased that you're here and I'm very pleased for the opportunity to participate in this important discussion.

Whenever you deal with such an important issue, and one on which reasonable people may differ in their thinking, I think it's essential to try to understand the perspective of all positions.

Since this is a session on regulation, I will begin by sharing some considerations from the regulators' perspective.

First of all, the challenge to regulatory boards has always been maintaining the balance between an individual's desire to practice a chosen profession and the board's responsibility to protect the public from unsafe practitioners. Reasonable people can differ in how best to protect the public. And our boards vary in their approaches to a number of issues. I think many regulators recognize that providing access to nursing care is part of protecting the public.

In granting an initial license to practice, regulators are looking at a generalist practice, a nursing license grants practice authority at this

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generalist level. Think of the nursing license as the key to any nursing role in any setting.

The burden of proving that an applicant meets all licensure requirements rests with the applicant. Remember that boards of nursing vary as to their structure and the level of discretion granted to them by the legislature.

Boards also vary in their philosophy and approach to regulation. The United States Constitution reserves police power to the state. Licensing authorities of states have traditionally been seen as part of that police power.

In considering applicants with disabilities, there are two distinct philosophies on how boards think and deal with these individuals. There are boards that have taken the position that the ADA is intended to "even the playing field" for applicants with disabilities. These boards ask few if any questions about functional abilities on their licensure applications. Their approach is to give the individual nurse an opportunity to self-limit his or her practice, if necessary, to make sure that any necessary accommodations are in place. The board would become involved only if there was a problem with practice reported. Other boards ask questions about functional abilities as one part of the information collected on licensure applications and use that information as part of the licensing decision.

I went to law school and can argue both of these positions. Besides disabilities, there are other ways practice can be self-limited. For example, I was a nurse before I attended law school. I practiced nursing in facilities and university hospital settings where either the resident or an IV team was responsible for venipuncture. While in law school, I worked for an agency that often sent me to various med-surg and critical care units. One of the first things I would do if a patient needed an IV restarted was to request assistance. I was not particularly interested in developing venipuncture skills because I was not going to be using them. I limited myself to situations where I could get the assistance I needed from other staff, or situations where I did not need the skill. I self-limited. Nurses with disabilities can similarly self-limit practice as needed and seek appropriate accommodations.

However, some boards believe that they are issuing a license that allows a nurse to practice in any role, any setting, the full range of nursing practice; therefore the board has a responsibility to identify needs for accommodations or practice limitations and assure that this critical information is available to employers. Now, this may be counter to the beliefs of many of you here at the symposium and those involved in the disability movement. Try to think a little more about where the boards are coming from. You have to understand that boards have experience with individuals who haven't demonstrated insight into their situations. Boards take their responsibility very seriously, and they believe that they have the responsibility to evaluate all aspects of competence.

I think technical skills raise concerns for boards. I think another area that raises concerns is the so-called invisible disabilities. As Dr. Carole Anderson noted, faculty also found invisible disabilities problematic. For example, think about many of the accommodations granted, like having a quiet room to take an exam. That sounds pretty reasonable to take an exam. But how many of us work in a nursing environment where there is a quiet room? I think this illustrates the nature of concerns that board members may have.

The functional ability study that was described by Dr. Yocom is very important, cutting-edge work. A panel of nurses initially identified these abilities, and I recall that the panel included both nurses with disabilities and nurses who had worked with nurses with disabilities, who made recommendations for the survey questionnaire.

The subsequent survey of nurses really pinpointed a point in time (early 1990's). As Karen McCulloh, RN, pointed out earlier today, that was nine years ago, and we live in a different technological world today. That different techno world has to be taken into consideration when establishing functional ability lists.

The functions that were identified in the study, especially some of the physical functions, should be thought of as things that need to be done as part of the nursing service. They don't necessarily have to be done by the same person. Stacey Carroll, RN, gave us a nice example about how she traded — she would do some things and another nurse would pick up things that hearing was really needed for. I think this is a great approach.

I also agree with what Andy Imparato, JD, talked about — thinking in a broader concept about the ability to communicate. You might not be able to communicate in one way, but able in another. All the technical resources we have now, should help — I have always thought nurses ought to be able to wear “star trek” devices so that they could record their nurse's notes as they are looking at a wound or doing an assessment.

The research that Dr. Yocom presented is about nine years old now and technology has changed dramatically in the last nine years.

Another thing to think about is that we are currently facing a nursing shortage of epic proportion. I realize that Dr. Goodman advised us to make changes because it is “the right thing to do.” That's an important message, but politically speaking, I think this is an opportune time because we need nurses. I am not just talking about new nurses coming into the field, but nurses who have been working in the field and have developed some kind of problem that may be preventing them from doing the full scope of what they envision as a staff nurse role.

We have to be creative in how we think about making accommodations. It is important that nursing board members are educated about the ADA law and educated with examples in providing reasonable accommodations. Real stories like the ones given by the student panel earlier today help to demonstrate successful accomplishments. Studies like the one the board conducted did inform and influence decision-making. We need to update that study. We need to do other kinds of studies. I would love to have somebody look at sentinel events and determine what part, if any, nurses with disabilities had in them. Is it the same proportion of sentinel events as the general nursing population? My hypothesis would be it's probably so, but we can't just accept hypothesis, we need sound data to inform our decision-making. We need to look at whether we need the same functional abilities that were identified from the earlier work conducted in 1993-94.

I think one of the things that really jumps to mind is being able to write with pen and pencil. Now, there are voice-activated computers that we can talk to for things like change of shift report. There are a lot

of technical solutions that we have to identify, and we have to demonstrate how they work.

We need to work to show how nurses with disabilities are effective. Currently, the National Council of State Boards of Nursing is working on a different study called an epidemiology of nursing error. The study is examining actual discipline cases, using a wonderful instrument that was developed with the assistance of Dr. Patricia Benner from the University of California at San Francisco. All kinds of elements are tracked including demographic information, the environment where the problem practice occurred, the type of area where it occurred, system issues, and potential negative contributions from other healthcare team members, e.g., a new resident who may have contributed to the sentinel event due to lack of experience. We also track practitioner contributions, e.g., did the nurse have a functional ability deficiency or a drug-chemical problem? We are hoping that this study will show trends that can be used to make changes or corrections to improve practice.

There are four things that I hope you will take away from my comments today. First of all, remember that state boards have different philosophies about the regulatory management of nurses with disabilities. Remember, that as long as they can articulate a rational relationship between the intent of a regulation and the activity or requirement that's being used, they are likely to be supported by the courts.

The second thing to remember is that the ADA was passed to provide opportunity. It was not intended to place healthcare clients or students at risk of harm. Under the ADA you cannot discriminate against an individual simply because he or she has a disability. You can, however, keep someone from practicing a profession if allowing that person to practice puts patients at risk of harm. How boards do this is very important.

The third thing is that we need research, especially within the current practice context, in order to have informed analysis and informed decision-making. We need to have sound data available so that the boards of nursing can make evidence-based decisions. The functional abilities as identified in Dr. Yocom's study provide guidelines that can be used for informed decision-making, but they are just one

piece. The context of the study was that it could be used as a resource for informed review and support decision-making regarding applicants and students with disabilities. It should be used in combination with other research and expert consultation. It represents what one group of professionals in one study recommended and what we validated at that point in time.

Finally, we need to be flexible, to be creative in accommodating individual challenges, to be open to new ways of practicing while maintaining patient safety.

At the same time, I think that educators have to reach a difficult balance. I don't think it is right to put unreasonable expectations in the mind of a student who may have significant problems becoming licensed to practice. Educators need to give students notice that there may be some speed bumps and barriers along the way. Once students are presented with this information then it becomes their informed decision to move forward — and it may be a good choice to become a nurse. Students with disabilities and colleges may devise some very innovative ways to accommodate students with disabilities.

We need to work with employers to show them the benefits of accommodations and to also encourage creativity in how work is done. Marca Bristo talked about how her nurse manager broke apart three job descriptions and reassembled the work to come up with a job that was very doable for a nurse in a wheelchair. That kind of job restructuring needs to be done more often. This is why we have to make sure that the employers buy into the idea because it won't matter if you get the education and license if you can't get a job.

We have to work together. The ADA created both opportunity and challenge: opportunity to work with prospective and current students to identify both alterations in their functional abilities and reasonable accommodations to support them in accomplishing their educational and career goals.

The challenge for educators is to provide opportunity and some creativity, but also maintain some reasonableness and provide notice to students of potential barriers.

The challenge for boards of nursing is to devise opportunity while maintaining standards for safe and effective nursing practice. Boards are accountable to the public first and then to the nurses.

I learned a lot today and I am going to take that knowledge back to the state board committees that I work with. I decided I really don't like the word disability. I think we're really talking about different abilities that can enable safe practice. Stacey Carroll, RN, who is able to lip-read and communicate that way has a different ability than others. I could have really used her in the ICU when I had patients with tracheostomies who were having difficulty communicating. We need data, we need to educate ourselves and we need to work with each other.

Again, thank you for the opportunity to participate today.

Audience Participation

Bobby Silverstein. I have a couple of questions. Vickie, I'm not sure I understand some of the information presented — maybe you could help. The second category type you described, the second approach that some state boards take in terms of re-licensure where the board says they re-license nurses if they can do everything nurses do, and you have Carolyn at this point in time in her career where she had not practiced clinical nursing for 15+ years and she is asking to be re-licensed but says, "Don't hire me to do clinical nursing because I can no longer do it, don't hire me to do this or that because I no longer do that type of nursing" — Would she fail the re-licensure?

Vickie Sheets. I hope not, because I'm in the same boat she is in.

Bobby Silverstein. I'm asking a conceptual question. Because if the answer is no, then it sounds more like a category 1 approach you described. Unless you're treating her experience different than the physical attribute.

Vickie Sheets. We're talking about the difference between initial licensure and re-licensure rules. The initial licensure is the point where those functional abilities are going to be evaluated. And there

are a couple ways of doing this. In our Model Practice Act we have what is called a modified license, which is a non-disciplinary approach. Other boards have to use the disciplinary approach.

Bob Silverstein. Excuse me, I don't understand the rule and the differences if the ultimate goal, which we all agree, is protection of the public. Which absolutely is the bottom line, ADA and everything else. If the overarching policy objective of approach 1 and approach 2 is to protect the public, why is the re-licensure or initial licensure relevant at all if you're not now able to protect the public? For Carolyn if a board is using approach 2 — why should Carolyn be able to practice or be, quote, “certified”? I don't get it.

Vickie Sheets. Excuse me. I think the answer to the question is that it's different in different states. In other words, the rule is not different for initial licensure versus re-licensure; it's different by states depending on whether the state uses the category 1 or 2 approach. In the states where our two colleagues are licensed, they use a type 1 approach. Period, whether you're initial or continuing. Whereas, in another state like Alaska, which was mentioned by Karen McCulloh, they use a type 2 approach. Which means that since your license allows you to do anything, it is the board's responsibility, as part of protecting the public, to limit your license related to your abilities. It's not initial licensure versus re-licensure; it's differences between states.

Bobby Silverstein. Then that's the follow-up to my question. If in fact I go to Rush University and I say I want to be the best researcher in the world in terms of issues affecting nursing, and I have no interest whatsoever in being in an ICU — what kind of license do I get if I cannot do three-quarters of the things a nurse usually does, but I'm the best damn researcher in the world? Do I get a qualified license or do I get no license?

Carolyn Yocom. It depends on the state in which you are applying for licensure. It all goes back to a phrase that Vicki had in her presentation that refers to the U.S. constitution — it gives the state the right to determine how it is going to approach licensure.

Bobby Silverstein. I understand.

Carolyn Yocom. Okay, but if I lived and worked in Alaska, I probably wouldn't get re-licensed. I have no intent of moving to Alaska. And because of the states' rights issue we have in this country, 61 Boards of Nursing and, therefore, 61 variations on a theme, any theme.

Bobby Silverstein. But there is an organization or a group that probably provides advice to states. And rather than answer the question by saying that's the way it is, in Alaska versus another state, to me the issue for this symposium is a different question. It's not what is, it's what should be.

Carolyn Yocom. That organization is the National Council of State Boards of Nursing. I worked there for 15 years. The National Council's role is that of a service organization to the boards of nursing. Included in that is the provision of information regarding important issues in education, practice and regulation, not just with regard to nursing, but with many other professions. One of the points that was in Vicki's presentation, or in the introduction of Vicki, is that she works with various National Council committees on what's called the model nurse practice act and the model rules and regulations. It is through that type of activity, and the inclusion of nursing board representatives on National Council's committees, that the Member Boards influence each other.

However, to paraphrase a common saying, you can lead a horse to water, but you cannot make them drink. This is because the National Council rather is a service organization. I think that's the piece that you have to remember. It can influence.

New Question. I am wondering, as a follow-up to that, how political or how arbitrary are the approaches and the determinations of whether Virginia does one thing and Illinois does another? I can understand the states' rights provision of the constitution, even as a non-lawyer I understand the states' rights provision. But I assume that it cannot be totally arbitrary. And so I am wondering who determines what the minimum standards are?

Vickie Sheets. The legislature. It is a totally political process.

Carolyn Yocom. Yes. Think about what you're dealing with here as public policy. In this case, it is much like for the nurses in the room, the whole issue of the minimal educational requirement for entry into licensure as a nurse. What the minimum education requirements are is in the law. If you don't like it, you then have to participate in the whole legislative change process. Because the board's responsibility is to implement the laws that have been passed by the legislatures.

Vickie Sheets. I think the most effective way to convince lawmakers is to have the data, to have evidence, not just the board's opinion on the basis of what they've seen in the past, not just your opinion on what you have experienced within this community. Have some facts. And I think that probably Rush College of Nursing could really help in this end in getting some research started in this area.

Beverly Huckman. I am a little concerned as I listen to this. As we have heard earlier today —and we know — Illinois has a pretty good ADA state law relative to people with disabilities. Then what you are saying to me is that that law should overarchingly govern what the Illinois board does. Is that correct? In other words, should that be as you said, the legislature. So I have to determine if the legislature doesn't establish the standards for nursing, organized medicine or anything else. In fact, we have someone here from the Illinois Department of Professional Regulation, maybe you can help. What is the impact of the legislature in Illinois on the decisions that are made by the Board?

Vickie Sheets. The Legislature passed the law that gives the board the authority to function.

Pat Hughes. I'm actually the newly appointed general counsel for the Illinois Department of Professional Regulations (IDPR). And my predecessor, who was with the agency for eight years, Adrienne Hirsch, is here as well.

I have not as much history to answer some of the follow-up questions you may have; Adrienne is more in a position to answer than I. To answer your question directly —which is the interaction between the legislature and the agency — the legislature sets up for nursing in Illinois a nurse practice act, which covers how it sets up a structure. It sets up minimum qualifications.

Do you have to take a test? The statute says that you do. So you do. Do you have to go to school? The statute says you do, so you do. The overlay on that are the administrative rules, which sometimes get into a little bit more detail both on testing and discipline. If you really talk about it in terms of a "political process," whom do you talk to if you don't like the law? You have to answer in two areas, one being the legislature and the other the regulatory agency. The regulatory agency often has some ability to join in the discussion on what the statute is going to be. You're always talking to the right person if you're talking to us (IDPR). We're part of the solution, not part of the problem in everything we're talking about today. But ultimately if it's the practice act, we don't make the practice act — the legislature has to change it and the governor has to sign it.

Bobby Silverstein. The third is the American's with Disabilities Act and the second is 504. If the statute or regulation says, notwithstanding everything we said above, do not apply for a license or otherwise allow a person with a disability to participate in anything related to nursing, that statute or regulation would not be okay.

Vickie Sheets. I think it's a big challenge.

Howard Rosenblum. I have a question related to your study. With all due respect to Dr. Yocom, I think that the approach was to ask the questions of the nurses who were practicing at that time what they thought were the essential duties. And I found that to be puzzling. And the reason is — I mean, that's just like asking in the old days if you were to ask a man if a woman could do a man's job. So naturally a man would say no. So if you ask a Caucasian person the same of a person of color, the person of color would also say the same thing. Before 1964. So to ask people without disabilities if it is really necessary to hear or to see or whatever, makes no sense. Because they have no concept of living with a disability, so I find the study to be flawed.

What we need to ask is if they can do the job with accommodations. And even asking that, you know, they still won't understand or get it. You have to look at it objectively, not subjectively.

Carolyn Yocom. First of all, there's a lot in the study that I didn't go into. But I do know that at least 10 percent of the participants did indicate that they possessed a disability. Many of them were visual, some were hearing problems, some were the usual array of musculoskeletal problems such as the bad backs, et cetera. So, there were some individuals with self-defined disabilities in the study. What we asked them was, for you to do your job yesterday, what did you need to be able to do. Now, that's the bottom line. What has to be done. The next question then in regards to the use of the study is how could it be done. And that's where the use of accommodations comes in.

We did ask those nurses who did self-disclose a disability what types of accommodations they used. The responses included things like having colleagues help do the heavy lifting or if they couldn't reach for something up high, to get someone to reach it for them. Or if they didn't understand what somebody was saying, to have them write it down. In the published study, there is a listing of those types of accommodations.

But that was seen as the second step. First, you have to identify what are the basic underlying abilities, the non-nursing specific functional abilities that you need to be able to perform given specific roles or functions or work settings. And then go from there with regard to how can that be accomplished in various and sundry creative ways.

New Speaker. I'd just like to point out that the definition of a disability is to be impaired substantially in something that most people find essential. Therefore, if you were to ask me what's essential to do my job as a lawyer, I would say walking, seeing, talking, hearing. Because I do all those things because that's what people without disabilities or those particular disabilities do. So then you would think that my job could only be done by a person who could walk and see and talk and hear and touch because I bring all of those abilities to my job.

You never asked in your study could you have done this, without this or that; could you have used a typewriter? Well, if I knew how to type I could use one. Could you have done it with an audio devise? You asked them what they did do. And what they do is use what they have, not what they don't know about. If you ask a blind person if it's

essential to see and they're leading a successful life, they're going to say no.

Carolyn Yocom. I don't disagree with you. I think you bring up a very good point. However, go back to my point that we had to identify what was baseline and go on from there. I understand completely where you're coming from. I have a disabled family member and this person's attitude is such that anything can be accomplished — it just takes longer, or in some cases it requires a different way of doing it. A person doesn't have to be able to clean the house in order to be a good wife — a housekeeper can be hired to do that kind of stuff.

New Speaker. I think the study questions didn't ask the able-bodied nurses/people functional questions — the study asked them what they did do, how they accomplished work. So naturally they responded by saying how they functioned at work.

Carolyn Yocom. Point taken. That was the purpose of the study.

New Speaker. I have a question. In regards to initial licensure, the scenario is a person has been in a nursing school and they are trying to complete an education. They want to become licensed and go to work. I'm interested in knowing if there's any data on how many people with disabilities go through the course work and are not licensed. I think this is the data we need to have. Also are they drummed out during the core courses, or do they go through all whole course work? I just want to know.

Carolyn Yocom. We do know by anecdotal information that most people who complete a nursing education program are declared eligible to take the licensure examination, NCLEX. Where we get into the whole issue regarding disabilities, is whether or not the board will certify them as eligible to take the licensure examination. There are no hard and fast statistics that are collected on this that I am aware of.

Vickie Sheets. I think there might be a way to look at that type of information. And, there might be a way that we could look into collecting the information. I think the next step is even more important. Does the person who's able to get through school and get licensed, are they able to get a job? Each piece is very important.

New Speaker. I have a question. And first of all I want to thank you for being here. I feel like we're in the meat of the subject now. So whatever our questions are, we love you, Okay?

Carolyn Yocom. I don't take any of this personally.

Speaker Continues. I have two questions. Number one, do you have any nurses with disabilities on your Board? Number two, do you have any statistics, any case studies, across the Board nationally where you know that nurses with disabilities have caused public harm?

Vickie Sheets. That's what we're hoping to find out in our epidemiology study. I'm not aware of any. There are some other regulatory people in the room. If any of you know of particular cases in your state, please speak up. I think that's a very good question. One of the things that kept going through my mind in this discussion today, is that some things that you view as prejudices, some regulators would view as serious concerns. I think that's why it's so important that we have this dialogue. And that we inform each other. I think that people disagree. I think people can disagree as to one of the challenges with the ADA being some of the terminology in defining it. Let me give you an example as to what we as a regulatory board see. A nurse who is hearing impaired, what would that nurse do if a patient calls for help and you can't see the call light? I can think of lots of ways you can work around it. You simply don't have the person work by themselves. It's that kind of thing. But it's important that the board review this type of issue and think it through because it is part of their responsibility.

Speaker's Second Question. What about membership of people?

Answer. Let me give you some help too. One of the things I would recommend is that you look at the EEOC guidelines on what is called an essential function. Because I wouldn't have thought of it the way that you defined it in terms of a dictionary view of it. Where you're going to be licensing people to go is into workplaces, in essence what the EEOC is going to look at are things like job descriptions that probably should or should not have in them things like needing to see, hear, walk. I don't think of those as essential functions. That's not why I went to school - to see, hear and walk. Those are things that I think of when you say definition of terms. That's where EEOC is coming from

because that's the guidance we're getting on the workplace. You'd think they'd all kind of come together at some point.

Vickie Sheets. Like I say, we need more work on them.

New Speaker. Two comments. First to the gentleman down here who said he didn't know how you got to your survey. And he was saying it's not the job. Well, you have to define the job first and then that's what you were doing.

Carolyn Yocom. That's correct!

Speaker Continues. When you ask 5,000 people what did you do yesterday at work, that is defining the job. And it's true that there are parts of the job that may be accommodated. But it is the job of nursing. Because if 95 percent of those working nurses said that's what I must do on my job as a nurse, that's a pretty good definition of what nurses do. It's just a comment.

And a comment to the first gentlemen asking questions (Bobby Silverstein) - when you asked whether Dr. Yocom should be licensed continuously, I will tell you that in today's nursing shortage, I graduated very similar to you -- and I'm really good at what I do. And my job is nursing. But if I were to go back to work in an ICU tomorrow, I would be quite dangerous, I think. I could fix that in about a month. I have an active license and they would hire me if I walked in the door. So there is a question. And I have a continuing concern about that.

So do all of us in the nursing profession know how to demonstrate continuing, general competence in nursing? Because I too would not work in an OB unit if you paid me because I would be down right dangerous. I don't try to work in areas like that because I monitor myself. Not because my Board of Nursing says I can't, because in this shortage environment I could work there.

Carolyn Yocom. If would like to make another comment. As I mentioned previously, the study used what's referred to as a job analysis methodology. This is a methodology that's been developed and used within the field of industrial psychology. The National Council uses this method as a way of identifying what is the nursing content and knowledge that a nurse needs to possess. It serves as the

underlying mechanism for establishing the content validity for the licensure examinations. This study then used an extension of that process, one that is more commonly used in fields outside of health professions.

For example, if you have a new company that is going to make widgets; in order for them to screen and hire individuals into positions who are competent to make the widgets, they need to be able to describe what it is that the individual needs to be able to do. That information underlies the job descriptions that are developed. So, if you go out into industry and you look at those job descriptions for a machinist, for example, it talks about being able to lift X amount of weight or pick up a piece of metal and be able to twist it, to turn it, to manipulate it, to turn this crank and so forth and so on. Those are skills that underlie the performance of that job.

In nursing, the knowledge base that you needed to possess is an important component of competence. However, there was nothing in the literature or anywhere else that described the other skills and abilities that a nurse needs to possess in order to perform their job safely and effectively. That was the basis for the study.

New Speaker. You mentioned that 10 percent, 300 of the nurses...

Carolyn Yocom. About 200 of them had disabilities.

Speaker Continues. The question then is, were the answers of those nurses different from the rest? Did they look at it from a different perspective?

Carolyn Yocom. That's a very good question, and I don't remember if we looked at it or not. It's been a number of years and I'm no longer at the Council. Therefore, I don't have the data. I just can't remember. Maybe we could look it up.

Vickie Sheets. I'm sure we still have it and I will take that question back.

New Speaker. What was just asked, in going back to sampling you had mentioned that disabled nurses participated, but we already

know that disabled nurses are underrepresented. So we don't have a good sample to which we can say that nurses with disabilities said that they can or cannot do X, Y, Z. And they may have a bachelor's degree, or be someone with a hearing impairment or hearing disability. Like me, I may say I don't need to hear, because I already know I can do the job with my hearing impairment — it's not the same. Just because you have disabled people, not all disabilities are the same and you're missing a whole layer of applicants.

Carolyn Yocom. I understand completely what you're saying. It's the same point as some of the other individuals have brought up. I said that we had, at one point convened focus groups composed of both individuals with disabilities and those without disabilities and others who had worked with nurses who had a disability of some sort or another. It was very, very difficult to identify individuals who had a disability so that we could invite them to participate in the focus group. This is because the Boards didn't have the information.

Remember, it was back in the early '90s when we did this study. To this day I'm sure there are Boards that ask on the application forms, "Do you have a disability?" Others don't. And if they don't ask, they're not going to know. So it was very difficult.

Nancy Spector. I'm told we're running out of time. Is there is one more burning question or remark?

Jean Bartels. I am from Georgia Southern University and the president-elect of the American Association of Colleges of Nursing. We're talking about a study that is dated and was pressuring job performance, expectations in acute care settings, which is pretty much where the majority of nurses worked in that time. We're in a different era. Moving out of an industrial age into a different one and we have an opportunity to recreate. Regulation will follow practice. I think we really need to look at the fact that the expectations for nurses today are far different and the nurse that we create for the future will look far different. That's the moment we are in. Again, no longer industrial age, we're just where Florence Nightingale was when she started her work and moving into the industrial age. I think we need to keep that in mind. The practice of nursing needs to change because a system in which these studies were done is broken. And there isn't a soul around who doesn't understand that from any of the

medical professions. We're all going to be seeing revolution and change. And this gathering has an opportunity to look at the place for all nurses in that situation.

Lois Halstead. A number of issues were presented and discussed today. Tomorrow after Bobby Silverstein presents insights into legislative change, we will break into three smaller groups: education, employment and regulations. During those sessions, with the help of a group leader, the groups will come up with recommendations, as specifically as possible, for change, ways to enact the recommendations, and potential barriers. The recommendations should be as pragmatic and realistic as possible in order to develop "next steps." We should be able to leave the symposium with next-steps ideas.

All of you were invited to the symposium because of expertise in your area and because you represent change agents. You have the ability to take what we're all learning here and to make a difference in different arenas of practice, education, employment and licensure/regulations. So tonight, please think about what we need to communicate to others, where we want to go and how we're going to get there. Thank you.